GREAT FALLS YOUTH TRANSITION CENTERS
DEPARTMENT OF CORRECTIONS

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STATE OF MONTANA

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4212 THIRD AVE
GREAT FALLS MT 59405

AUTHORIZATION/CONSENT TO SEEK MEDICAL CARE

I, the below signed parent(s)/guardian(s) of _____, grant permission and authorize the Great Falls Youth Transition Center Director or designee to sign for all necessary medical care, routine tests, immunizations, treatment, emergency medical or surgical treatment in the event that I cannot be contacted.

I understand that the Transition Center staff will notify me, as soon as possible, in the event of an emergency in which my child requires immediate medical attention. I agree to pay for all medical expenses incurred by my child not covered by insurance or Medicaid.

Below is a list of persons and telephone numbers which may aid Youth Transition Centers' staff to locate me if medical attention for my child is required:

Name	Phone
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature/Relationship Date Phone

_____ _____
Youth Transition Center Staff Date